

		FOR OHF USE					

LL 1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0042739</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																	
Facility Name: <u>Lexington of Chicago Ridge</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																	
Address: <u>10300 Southwest Highway</u> <u>Chicago Ridge</u> <u>60145</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																	
County: <u>Cook</u>																			
Telephone Number: <u>(708) 425-1100</u> Fax # <u>(708) 425-0779</u>																			
IDPA ID Number: <u>36734823001</u>																			
Date of Initial License for Current Owners: <u>05/27/91</u>																			
Type of Ownership:																			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input checked="" type="checkbox"/> PROPRIETARY																	
<input type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual																	
<input type="checkbox"/> Trust		<input type="checkbox"/> State																	
IRS Exemption Code _____		<input type="checkbox"/> Partnership																	
		<input type="checkbox"/> Corporation																	
		<input type="checkbox"/> County																	
		<input type="checkbox"/> Other _____																	
		<input checked="" type="checkbox"/> "Sub-S" Corp. _____																	
		<input type="checkbox"/> Limited Liability Co. _____																	
		<input type="checkbox"/> Trust																	
		<input type="checkbox"/> Other _____																	
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 384-6000</u> Please send copies of desk review and audit adjustments to address on this page		<table border="1"> <tr> <td rowspan="2"> Officer or Administrator of Provider </td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4"> Paid Preparer </td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td colspan="2"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # <u>(217) 782-1630</u> </td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # <u>(217) 782-1630</u>	
Officer or Administrator of Provider	(Signed) _____																		
	(Date) _____																		
Paid Preparer	(Type or Print Name) _____																		
	(Title) _____																		
	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>																		
	(Date) _____																		
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	(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>																		
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MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # <u>(217) 782-1630</u>																			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>224</u>	Skilled (SNF)	<u>224</u>	<u>81,984</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>224</u>	TOTALS	<u>224</u>	<u>81,984</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>35,257</u>	<u>4,685</u>	<u>12,814</u>	<u>52,756</u>	8
9	SNF/PED					9
10	ICF	<u>20,731</u>	<u>1,116</u>	<u>358</u>	<u>22,205</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>55,988</u>	<u>5,801</u>	<u>13,172</u>	<u>74,961</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.43%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/04/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date New constructionNO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 224 and days of care provided 10,929Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	302,180	29,761	15,587	347,528		347,528		347,528		1
2	Food Purchase		302,136		302,136		302,136	(11,764)	290,372		2
3	Housekeeping	275,812	30,246		306,058		306,058	324	306,382		3
4	Laundry	69,211	22,305		91,516		91,516	(2,155)	89,361		4
5	Heat and Other Utilities			192,604	192,604		192,604	3,703	196,307		5
6	Maintenance	32,586		94,288	126,874		126,874	47,573	174,447		6
7	Other (specify):* Allocated Benefits							5,354	5,354		7
8	TOTAL General Services	679,789	384,448	302,479	1,366,716		1,366,716	43,035	1,409,751		8
	B. Health Care and Programs										
9	Medical Director			30,825	30,825		30,825		30,825		9
10	Nursing and Medical Records	3,242,696	245,406	51,148	3,539,250		3,539,250	62,539	3,601,789		10
10a	Therapy			961,217	961,217		961,217		961,217		10a
11	Activities	210,700	19,281	3,467	233,448		233,448		233,448		11
12	Social Services	91,235		2,909	94,144		94,144		94,144		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Allocated Benefits							7,562	7,562		15
16	TOTAL Health Care and Programs	3,544,631	264,687	1,049,566	4,858,884		4,858,884	70,101	4,928,985		16
	C. General Administration										
17	Administrative	108,768		1,027,802	1,136,570		1,136,570	(922,544)	214,026		17
18	Directors Fees										18
19	Professional Services			56,793	56,793		56,793	10,222	67,015		19
20	Dues, Fees, Subscriptions & Promotions			13,320	13,320		13,320	971	14,291		20
21	Clerical & General Office Expenses	245,765	34,548	19,396	299,709		299,709	296,603	596,312		21
22	Employee Benefits & Payroll Taxes			669,104	669,104		669,104	11,764	680,868		22
23	Inservice Training & Education			1,476	1,476		1,476		1,476		23
24	Travel and Seminar			2,582	2,582		2,582	4,039	6,621		24
25	Other Admin. Staff Transportation			2,962	2,962		2,962	10,391	13,353		25
26	Insurance-Prop.Liab.Malpractice			206,295	206,295		206,295	4,626	210,921		26
27	Other (specify):* Allocated Benefits							45,620	45,620		27
28	TOTAL General Administration	354,533	34,548	1,999,730	2,388,811		2,388,811	(538,308)	1,850,503		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,578,953	683,683	3,351,775	8,614,411		8,614,411	(425,172)	8,189,239		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of Chicago Ridge

#0042739

Report Period Beginning:

01/01/04

Ending:

12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			71,199	71,199		71,199	178,377	249,576			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,242	4,242		4,242	303,103	307,345			32
33	Real Estate Taxes							521,059	521,059			33
34	Rent-Facility & Grounds			1,698,477	1,698,477		1,698,477	(1,696,985)	1,492			34
35	Rent-Equipment & Vehicles			8,512	8,512		8,512	3,146	11,658			35
36	Other (specify):*											36
37	TOTAL Ownership			1,782,430	1,782,430		1,782,430	(691,300)	1,091,130			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		314,035		314,035		314,035		314,035			39
40	Barber and Beauty Shops			20,675	20,675		20,675		20,675			40
41	Coffee and Gift Shops			7,274	7,274		7,274		7,274			41
42	Provider Participation Fee			122,976	122,976		122,976		122,976			42
43	Other (specify):* Nonallowable Costs			188,470	188,470		188,470	(188,470)				43
44	TOTAL Special Cost Centers		314,035	339,395	653,430		653,430	(188,470)	464,960			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,578,953	997,718	5,473,600	11,050,271		11,050,271	(1,304,942)	9,745,329			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms	(774)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients	(2,155)	4		8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(17,309)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(744)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(450)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(141,219)	43		24
25 Fund Raising, Advertising and Promotional	(13,641)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax	(3,028)	43		26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See attached Schedule A	(37,528)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (216,848)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(1,088,094)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (1,088,094)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (1,304,942)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Chicago Ridge

Provider #: 0042739

01/01/04 to 12/31/04

Schedule A

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Disallow nonallowable radiology	(19,576)	43
Disallow nonallowable laboratory	(8,275)	43
Nonallowable collection fees	(7,812)	19
Miscellaneous income	(11)	21
Nonallowable unclaimed property expense	(523)	21
Nonallowable personal replacement costs	(791)	43
Real Estate Refund Cost	717	33
Disallow out of period legal fees	(1,257)	19
Total	<u>(37,528)</u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Chicago Ridge

ID# 0042739

Report Period Beginning: 01/01/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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21			21
22			22
23			23
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27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/04

12/31/04

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	146,972	0	31,405	0	0	0	0	0	0	0	178,377	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,309)	320,032	0	380	0	0	0	0	0	0	0	303,103	32
33	Real Estate Taxes	0	498,477	0	1,650	0	0	0	0	0	0	0	500,127	33
34	Rent-Facility & Grounds	0	(1,698,477)	0	1,492	0	0	0	0	0	0	0	(1,696,985)	34
35	Rent-Equipment & Vehicles	0	0	0	3,146	0	0	0	0	0	0	0	3,146	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,309)	(732,996)	0	38,073	0	0	0	0	0	0	0	(712,232)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(159,856)	28	0	0	0	0	0	0	0	0	0	(159,828)	43
44	TOTAL Special Cost Centers	(159,856)	28	0	0	0	0	0	0	0	0	0	(159,828)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(179,320)	(712,524)	553,522	(929,092)	0	0	0	0	0	0	0	(1,267,414)	45

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Schedule B		See attached Schedule B		Sambell of Chicago Ridge		
				Limited Partnership	Chicago Ridge	Real estate ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional fees	\$	Sambell of Chicago Ridge Limited Partnership	**	\$ 20,334	\$ 20,334	1
2	V							2
3	V	30 Depreciation		Sambell of Chicago Ridge Limited Partnership	**	146,972	146,972	3
4	V	32 Interest expense		Sambell of Chicago Ridge Limited Partnership	**	316,823	316,823	4
5	V	32 Amortization of mortgage costs		Sambell of Chicago Ridge Limited Partnership	**	3,209	3,209	5
6	V	33 Property taxes		Sambell of Chicago Ridge Limited Partnership	**	498,477	498,477	6
7	V	34 Rental expense	1,698,477	Sambell of Chicago Ridge Limited Partnership	**		(1,698,477)	7
8	V	43 State replacement tax		Sambell of Chicago Ridge Limited Partnership	**	28	28	8
9	V	21 Bank charges		Sambell of Chicago Ridge Limited Partnership	**	110	110	9
10	V							10
11	V			** The owners of Lexington Health Care Center of Chicago Ridge, Inc. own 100%				11
12	V			of Sambell of Chicago Ridge Limited Partnership				12
13	V							13
14	Total		\$ 1,698,477			\$ 985,953	\$ * (712,524)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.

Provider # 0036996

1/1/04 - 12/31/04

Schedule B

VII. Related Parties

Owners

<u>Name</u>	<u>Ownership %</u>
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 324	\$ 324
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	3,521	3,521
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	93	93
18	V	5 Utilities - maintenance office		Royal Management Corp.	**	89	89
19	V	6 Management allocation - salaries		Royal Management Corp.	**	44,272	44,272
20	V	6 Repairs & maintenance		Royal Management Corp.	**	3,301	3,301
21	V	7 Management allocation - employee benefits		Royal Management Corp.	**	5,354	5,354
22	V	10 Management allocation - salaries		Royal Management Corp.	**	62,539	62,539
23	V	15 Management allocation - employee benefits		Royal Management Corp.	**	7,562	7,562
24	V	17 Management allocation - salaries		Royal Management Corp.	**	105,258	105,258
25	V	19 Computer consultant & supplies		Royal Management Corp.	**	11,783	11,783
26	V	19 Professional fees		Royal Management Corp.	**	7,389	7,389
27	V	20 Dues & subscriptions		Royal Management Corp.	**	871	871
28	V	20 Licenses, permits & inspections		Royal Management Corp.	**	23	23
29	V	20 Advertising - help wanted		Royal Management Corp.	**	77	77
30	V	21 Management allocation - salaries		Royal Management Corp.	**	272,001	272,001
31	V	21 Bank charges		Royal Management Corp.	**	2,164	2,164
32	V	21 Office supplies & printing		Royal Management Corp.	**	9,192	9,192
33	V	21 Postage		Royal Management Corp.	**	3,766	3,766
34	V	21 Telephone		Royal Management Corp.	**	9,904	9,904
35	V	24 Travel & seminar		Royal Management Corp.	**	4,039	4,039
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. Own 100% of Royal Management Corp.					
39	Total		\$			\$ 553,522	\$ * 553,522

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	25 Auto expense	\$	Royal Management Corp.	**	\$ 10,391	\$ 10,391
16	V	26 Insurance general		Royal Management Corp.	**	4,626	4,626
17	V	27 Management allocation - employee benefits		Royal Management Corp.	**	45,620	45,620
18	V	30 Depreciation - vehicles		Royal Management Corp.	**	3,370	3,370
19	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	7,307	7,307
20	V	30 Depreciation - equipment		Royal Management Corp.	**	20,728	20,728
21	V	32 Interest		Royal Management Corp.	**	380	380
22	V	33 Property taxes		Royal Management Corp.	**	1,650	1,650
23	V	34 Rent expense		Royal Management Corp.	**	1,492	1,492
24	V	35 Equipment rental		Royal Management Corp.	**	3,146	3,146
25	V	17 Management fees	1,027,802	Royal Management Corp.	**		(1,027,802)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V	** Certain owners of Lexington Health Care Center of Chicago Ridge, Inc. Own 100% of Royal Management Corp.					
39	Total		\$ 1,027,802			\$ 98,710	\$ * (929,092)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/Officer	Administrative	22.33%	See Schedule C	4	8%	Salary	\$ 35,026	L17, C7	1
2	John Samatas	Owner/Officer	Admin/Plant Ops	22.33%	See Schedule C	3	6%	Salary	25,019	L17, C7	2
3	Cynthia Thiem	Owner/Officer	Administrative	22.34%	See Schedule C	3	8%	Salary	25,019	L17, C7	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	2%	Salary	6,094	L17, C7	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	6	12%	Salary	14,100	L17, C7	5
6											6
7											7
8					All individuals work in excess of 40 hours per week.						8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 105,258		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/04 - 12/31/04

Schedule C

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives
and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

<u>Name of facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>George Samatas</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Bloomingdale, Inc.	19,211	26,895	19,211	4,679	10,827	80,823
Lexington Health Care Center of Elmhurst, Inc.	16,754	23,455	16,754	4,081	9,442	70,486
Lexington Health Care Center of LaGrange, Inc.	12,174	17,044	12,174	2,965	6,861	51,218
Lexington Health Care Center of Lake Zurich, Inc.	23,790	33,306	23,790	5,795	13,408	100,089
Lexington Health Care Center of Lombard, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Orland Park, Inc.	30,154	42,219	30,154	7,346	16,995	126,868
Lexington Health Care Center of Schaumburg, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Streamwood, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Wheeling, Inc.	24,684	34,557	24,684	6,012	13,912	103,849
Total	201,824	282,554	201,824	49,160	113,745	849,107

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	743,346	10	\$ 2,938	\$	81,984	\$ 324	1
2	5	Utilities - gas & electric	Bed Days	743,346	10	31,920		81,984	3,521	2
3	5	Utilities - water & sewer	Bed Days	743,346	10	846		81,984	93	3
4	5	Utilities - maintenance office	Bed Days	743,346	10	808		81,984	89	4
5	6	Management allocation - salaries	Bed Days	743,346	10	401,410	401,410	81,984	44,272	5
6	6	Repairs & maintenance	Bed Days	743,346	10	29,930		81,984	3,301	6
7	7	Management allocation - employee	Bed Days	743,346	10	48,540		81,984	5,354	7
8	10	Management allocation - salaries	Bed Days	743,346	10	567,037	567,037	81,984	62,539	8
9	15	Management allocation - employee	Bed Days	743,346	10	68,569		81,984	7,562	9
10	17	Management allocation - salaries	Bed Days	743,346	10	954,365	954,365	81,984	105,258	10
11	19	Computer consultant & supplies	Bed Days	743,346	10	106,838		81,984	11,783	11
12	19	Professional fees	Bed Days	743,346	10	66,993		81,984	7,389	12
13	20	Dues & subscriptions	Bed Days	743,346	10	7,893		81,984	871	13
14	20	Licenses, permits & inspections	Bed Days	743,346	10	212		81,984	23	14
15	20	Advertising - help wanted	Bed Days	743,346	10	698		81,984	77	15
16	21	Management allocation - salaries	Bed Days	743,346	10	2,466,223	2,466,223	81,984	272,001	16
17	21	Bank charges	Bed Days	743,346	10	19,618		81,984	2,164	17
18	21	Office supplies & printing	Bed Days	743,346	10	83,348		81,984	9,192	18
19	21	Postage	Bed Days	743,346	10	34,142		81,984	3,766	19
20	21	Telephone	Bed Days	743,346	10	89,797		81,984	9,904	20
21	24	Travel & seminar	Bed Days	743,346	10	36,624		81,984	4,039	21
22										22
23										23
24										24
25	TOTALS					\$ 5,018,749	\$ 4,389,035		\$ 553,522	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge# 0042739

Report Period Beginning:

01/01/04Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

(630) 458-4700

Fax Number

(630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	743,346	10	\$ 94,217	\$ 81,984	\$ 10,391	1
2	26	Insurance general	Bed Days	743,346	10	41,943	81,984	4,626	2
3	27	Management allocation - employee	Bed Days	743,346	10	413,634	81,984	45,620	3
4	30	Depreciation - vehicles	Bed Days	743,346	10	30,557	81,984	3,370	4
5	30	Depreciation - leasehold improv.	Bed Days	743,346	10	66,255	81,984	7,307	5
6	30	Depreciation - equipment	Bed Days	743,346	10	187,937	81,984	20,728	6
7	32	Interest	Bed Days	743,346	10	3,446	81,984	380	7
8	33	Property taxes	Bed Days	743,346	10	14,963	81,984	1,650	8
9	34	Rent expense	Bed Days	743,346	10	13,526	81,984	1,492	9
10	35	Equipment rental	Bed Days	743,346	10	28,527	81,984	3,146	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 895,005	\$	\$ 98,710	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge # 0042739 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Lexington Financial						\$					\$	1
2	Services II, L.L.C.	X		Mortgage	\$42,300.00	12/29/98	5,563,000	4,605,669	01/01/08	0.0675	316,823		2
3													3
4													4
5													5
	Working Capital												
6	LaSalle Bank, N.A.		X	Working capital	Varies	04/06/02	1,000,000	400,000	5/31/05	Prime	4,242		6
7													7
8													8
9	TOTAL Facility Related				\$42,300.00		\$ 6,563,000	\$ 5,005,669				\$ 321,065	9
	B. Non-Facility Related*												
10							Amortization of mortgage costs				3,209		10
11							Interest income offset				(17,309)		11
12							Allocated from management company				380	12	
13													13
14	TOTAL Non-Facility Related						\$					\$ (13,720)	14
15	TOTALS (line 9+line14)						\$ 6,563,000	\$ 5,005,669				\$ 307,345	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Lexington of Chicago Ridge**# **0042739** Report Period Beginning: **01/01/04** Ending: **12/31/04****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.			\$	565,200	1
			Allocation from management company		
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003		\$	534,109	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(29,441)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	531,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	20,932	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ 2,148 For 1997 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(1,432)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	521,059	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	462,509	8	
		2000	478,861	9	
		2001	499,417	10	
		2002	551,245	11	
		2003	534,109	12	
2004 assessment	2,200,838				
Equalization factor	2.4598				
Tax Rate:	0.098230				
Estimated 2004 taxes:	531,780				
Use:	531,000				

		FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Chicago Ridg COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042739

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>24-18-200-030-0000</u>	<u>Land & Building</u>	\$ <u>520,658.00</u>	\$ <u>520,658.00</u>
2. <u>24-07-311-012-0000</u>	<u>Land & Building</u>	\$ <u>13,451.00</u>	\$ <u>13,451.00</u>
3. <u>Royal Management Corp. (Samvest of Lombard II)</u>		\$	\$
4. <u>05-01-202-019</u>	<u>Land & Building</u>	\$ <u>187,600.00</u>	\$ <u>1,650.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>721,709.00</u>	\$ <u>535,759.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

A.

Square Feet:

85,551

B.

General Construction Type:

Exterior

Concrete Block

Frame

Steel

Number of Stories

3

C.

Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	31,000	1989	\$ 505,000	1
2	Allocation from management company			17,683	2
3	TOTALS	31,000		\$ 522,683	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	215	1991	1991	\$ 5,143,342	\$	35	\$ 146,953	\$ 146,953	\$ 1,996,108
5	9	1995	1995	97,352	2,781	35	2,781		26,423
6									
7									
8									
Improvement Type**									
9	Leasehold Improvements	1993		2,694	77	35	77		887
10	Leasehold Improvements	1994		6,581	188	35	188		1,974
11	Dishwasher hood	1996		2,480	248	10	248		2,108
12	Lobby repairs	1996		8,698	870	10	870		7,394
13	Basement rehab	1997		24,477	2,448	10	2,448		19,174
14	Wiring	1998		3,428	343	10	343		2,229
15	Handrails	1998		895	60	15	60		389
16	Resurface & restripe parking lot	1998		4,450	445	10	445		2,892
17	Fire wall	1998		2,169	62	35	62		403
18	Foyer floor tile	1999		32,379	3,238	10	3,238		18,888
19	Wallpapering / painting / decorating	1999		8,833	883	10	883		4,637
20	Rebuild garage area	1999		1,762	50	35	50		259
21	Roof repairs	2000		6,240	624	10	624		2,808
22	Electrical wiring	2000		3,986	114	35	114		513
23	Electrical wiring	2000		2,536	72	35	72		325
24	Kitchen rehab	2000		6,623	221	35	221		994
25	Automatic doors	2000		1,300	130	10	130		585
26	Elevator eye sensors	2000		4,500	300	15	300		1,350
27	Resurface & restripe parking lot	2001		3,319	332	10	332		1,162
28	Door releases	2001		5,200	520	10	520		1,820
29	Carpeting	2001		10,022	1,002	10	1,002		3,507
30	Roof repairs	2002		25,600	1,280	20	1,280		3,627
31	Elevator upgrade	2002		9,866	986	10	986		2,548
32	Painting/decorating/carpet/wallpaper	2003		38,165	1,908	20	1,908		3,816
33	Rehab/new office	2003		26,733	1,337	20	1,337		2,674
34	Facility rehab - construction costs, painting & decorating	2003		257,174	12,859	20	12,859		19,288
35	Facility rehab - electrical	2003		12,840	642	20	642		963
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Facility rehab - carpeting	2003	\$ 7,800	\$ 780	10	\$ 780	\$	\$ 1,170		37
38	Facility rehab - floor tile	2003	3,548	177	20	177		266		38
39	Kickplates/Door protectors	2004	4,095	273	10	273		273		39
40	Kitchen Fire Protection Upgrade	2004	1,428	95	10	95		95		40
41										41
42	Land improvements - management company	2002	27,870		15	1,824	1,824	5,419		42
43	Building - management company	2002	216,828		40	5,320	5,320	15,810		43
44	HVAC, electrical, security system - management company	2003	2,149		30	146	146	204		44
45	Key card system - management company	2004	338		20	17	17	17		45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 6,017,700	\$ 35,345		\$ 189,605	\$ 154,260	\$ 2,152,999		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 265,609	\$ 32,908	\$ 32,908	\$	5-10 yrs	\$ 125,684	71
72	Current Year Purchases	40,848	2,965	2,965		3-10 yrs	2,965	72
73	Fully Depreciated Assets	456,265					456,265	73
74	Allocated from Mgmt Co.	207,982		20,728	20,728		86,865	74
75	TOTALS	\$ 970,704	\$ 35,873	\$ 56,601	\$ 20,728		\$ 671,779	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from Mgmt Co.			43,526		3,370	3,370		29,907	79
80	TOTALS			\$ 43,526	\$	\$ 3,370	\$ 3,370		\$ 29,907	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,554,613	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,218	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 249,576	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 178,358	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,854,685	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Rehab Facility Tile Floor	\$ 35,275	92
93	Lower Level Therapy Rehab	1,811	93
94	First Floor Therapy	185	94
95		\$ 37,271	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from management company				1,492			6
7	TOTAL				\$ 1,492			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 11,658 Description: Copier: \$8,242, Fax \$270; Allocation from management company: \$3,146
(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2005 \$ _____
13. _____/2006 \$ _____
14. _____/2007 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	7,757	\$ 421,707	\$	7,757	\$ 421,707	1					
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		209	17,116		209	17,116	2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist	L10A, C3	hrs		8,950	522,394		8,950	522,394	4					
5	Physician Care		visits							5					
6	Dental Care		visits							6					
7	Work Related Program		hrs							7					
8	Habilitation		hrs							8					
9	Pharmacy	L39, C2	# of prescripts				314,035		314,035	9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10					
11	Academic Education		hrs							11					
12	Exceptional Care Program									12					
13	Other (specify):									13					
14	TOTAL			\$	16,916	\$ 961,217	\$ 314,035	16,916	\$ 1,275,252	14					

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 466,110	\$ 478,916	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 814,000)	2,138,871	2,138,871	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,273	61,273	6
7	Other Prepaid Expenses	15,138	15,138	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow		109,184	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,681,392	\$ 2,803,382	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,430	7,430	12
13	Land		522,683	13
14	Buildings, at Historical Cost		5,143,342	14
15	Leasehold Improvements, at Historical Cost	627,173	874,358	15
16	Equipment, at Historical Cost	372,621	1,014,230	16
17	Accumulated Depreciation (book methods)	(333,304)	(2,854,685)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify construction in progress)	37,270	37,270	22
23	Other(specify): Unamortized mortgage costs		44,919	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 711,190	\$ 4,789,547	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,392,582	\$ 7,592,929	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 448,764	\$ 448,764	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	400,000	400,000	29
30	Accrued Salaries Payable	285,119	285,119	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,371	2,371	31
32	Accrued Real Estate Taxes(Sch.IX-B)		531,000	32
33	Accrued Interest Payable		25,907	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	513,205	109,022	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,649,459	\$ 1,802,183	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,605,669	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,605,669	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,649,459	\$ 6,407,852	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,743,123	\$ 1,185,077	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,392,582	\$ 7,592,929	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Lexington Health Care Center of Chicago Ridge, Inc.
Provider # 0036996
1/1/04 - 12/31/04

Schedule E

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued rent	404,183	
Accrued management fees	37,621	37,621
Accrued 401(k) contribution	43,737	43,737
Due to related party	1,776	1,776
Other accrued expenses	25,888	25,888
	<hr/>	<hr/>
Total line 36	<u>513,205</u>	<u>109,022</u>

XVII. Income Statement

E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Investment Income in Lexington Financial Services II, L	74
Vending machine Commission	1,932
State bedhold Income	(468)
Miscellaneous Income	11
	<hr/>
Total line 28	<u>1,549</u>

See Accountants' Compilation Report

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,230,976	1
2	Restatements (describe):		2
3	Post Closing Adjustments	50,265	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,281,241	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,037,882	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(576,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 461,882	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,743,123	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Lexington of Chicago Ridge

0042739

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,656,385	1
2	Discounts and Allowances for all Levels	(977,184)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,679,201	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,848,578	6
7	Oxygen	2,156	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,850,734	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	9,194	12
13	Barber and Beauty Care	25,387	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	11	15
16	Rental of Facility Space		16
17	Sale of Drugs	397,013	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,637	19
20	Radiology and X-Ray	20,078	20
21	Other Medical Services	58,885	21
22	Laundry	2,155	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 539,360	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	17,309	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,309	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	1,549	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,549	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,088,153	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,366,716	31
32	Health Care	4,858,884	32
33	General Administration	2,388,811	33
B. Capital Expense			
34	Ownership	1,782,430	34
C. Ancillary Expense			
35	Special Cost Centers	530,454	35
36	Provider Participation Fee	122,976	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,050,271	40
41	Income before Income Taxes (line 30 minus line 40)**	1,037,882	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,037,882	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files a cash basis tax return.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Lexington of Chicago Ridge**# **0042739**Report Period Beginning: **01/01/04**Ending: **12/31/04**

12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,973	2,210	\$ 102,688	\$ 46.47	1
2	Assistant Director of Nursing	2,539	2,830	90,467	31.97	2
3	Registered Nurses	48,364	52,567	1,520,598	28.93	3
4	Licensed Practical Nurses	11,278	12,273	267,503	21.80	4
5	Nurse Aides & Orderlies	94,900	102,073	1,143,268	11.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,666	9,694	118,172	12.19	8
9	Activity Director	1,675	1,731	27,715	16.01	9
10	Activity Assistants	17,342	18,856	182,985	9.70	10
11	Social Service Workers	4,152	4,539	91,235	20.10	11
12	Dietician	2,042	2,312	38,238	16.54	12
13	Food Service Supervisor	2,050	2,108	25,941	12.31	13
14	Head Cook	1,962	2,153	23,596	10.96	14
15	Cook Helpers/Assistants	11,790	12,752	106,338	8.34	15
16	Dishwashers	16,869	17,756	108,067	6.09	16
17	Maintenance Workers	2,204	2,366	32,586	13.77	17
18	Housekeepers	37,157	39,992	275,812	6.90	18
19	Laundry	9,541	10,412	69,211	6.65	19
20	Administrator	1,960	2,258	108,768	48.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,074	17,022	245,765	14.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	292,538	315,904	\$ 4,578,953 *	\$ 14.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	273	\$ 15,587	L1, C3	35
36	Medical Director	Monthly	30,825	L9, C3	36
37	Medical Records Consultant	14	767	L10, C3	37
38	Nurse Consultant	7	406	L10, C3	38
39	Pharmacist Consultant	Monthly	1,100	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	72	3,467	L11, C3	44
45	Social Service Consultant	65	2,909	L12, C3	45
46	Other(specify)				46
47	Rehabcare	Monthly	110	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	431	\$ 55,171		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Marichu Bueno	Administrator	0.00%	\$ 108,768	Workers' Compensation Insurance		\$ 79,793	IDPH License Fee		\$		
				Unemployment Compensation Insurance		34,938	Advertising; Employee Recruitment		3,688		
				FICA Taxes		336,981	Health Care Worker Background Check (Indicate # of checks performed 83)		1,000		
				Employee Health Insurance		163,249	Miscellaneous Dues & Subs		64		
				Employee Meals		11,764	Miscellaneous Licenses & Permits		8,568		
				Illinois Municipal Retirement Fund (IMRF)*							
				401(k) Contributions		31,116					
				Other Employee Benefits		23,027					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)											
\$ 108,768											
B. Administrative - Other											
Description				Amount							
Management fees (eliminated in column 7)				\$ 1,027,802							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 1,027,802		TOTAL (agree to Schedule V, line 22, col.8) \$ 680,868					
C. Professional Services						E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Vendor/Payee	Type		Amount	Description	Line #	Amount	G. Schedule of Travel and Seminar**				
Altschuler, Melvoin & Glasser LLP	Accounting		\$ 15,656			\$	Description				
American Express Tax & Bus. Svcs.	Accounting		5,352				Amount				
Grabowski Law Center, LLC.	Collections		1,463	N/A			Out-of-State Travel				
James Samatas	Legal		100				\$				
Personnel Planners	U/C Consulting		1,537								
Carol Jeschke	Staffing Consultant		1,106				In-State Travel				
Sachnoff & Weaver	Legal		11,687								
Scott & Krause	Legal		228				Seminar Expense				
							2,582				
							Allocated from management company				
							4,039				
							Entertainment Expense				
See attached Schedule F			19,664				(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$ 56,793		TOTAL		\$			
								(agree to Sch. V, line 24, col. 8)			
								\$ 6,621			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

Lexington Health Care Center of Chicago Ridge, Inc.
 Provider # 0036996
 1/1/04- 12/31/04

Schedule F

XIX. Support Schedules
 C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Katten Muchin Zavis Rosenman	Legal	1,264
eHealth Solutions	Computer Services	3,600
Advanced Answers on Demand, Inc.	Computer Services	2,652
AdminaStar	Computer Services	396
Gigatrend	Computer Services	195
Information Controls, Inc.	Computer Services	1,156
Lanac	Computer Services	792
National Datacare	Computer Services	2,550
Covad Communications	Computer Services	710
Various	Collections	6,349
		<u>19,664</u>
Total, Agrees to Schedule V, Line 19, Column 3		<u>56,793</u>
Allocated from management co.		
American Express Tax & Business Services	Accounting	335
AM & G	Accounting	536
AccountTemps	Accounting	912
Avail Corporation	Accounting	26
Gilson, Labus and Silverman	Accounting	276
Doris Fischer	Medicaid Billing Consultant	2,348
James Samatas	Legal	39
Sachnoff and Weaver	Legal	1,094
ING / Pension Administrators	401 (k) Administration	97
Pension Administrators	401 (k) Administration	862
Personnel Planners	U/C Consulting	13
Susan Parker, LCSW	DNR Consulting	12
Eric Hader	Consultant	29
Gene Whitehorn	Medicaid Billing Consultant	811
Various	Computer Consulting	11,783
Allocated from building partnership		
James Samatas	Filing and recording fees	118
McCracken, Walsh, de Lavan & Hetler	Real estate legal fees	8,480
Liston & Lafakis, PC	Real estate legal fees	11,735
Nonallowable legal fees		
Grabowski Law Center, LLC	Collection fees	(1,463)
Various	Collection fees	(6,349)
Disallow out of period legal fees		
Scott & Kraus, LLC	Out of period fees	(228)
Katten Muchin Zavis Rosenman	Out of period fees	(1,029)
Reclassifications		
McCracken, Walsh, de Lavan & Hetler	Real estate legal fees	(8,480)
Liston & LaFakis, PC	Real estate legal fees	(11,735)
Total, Agrees to Schedule V, Line 19, Column 8		<u>67,015</u>

See Accountants' Compilation Report.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number <u>Lexington of Chicago Ridge</u>	STATE OF ILLINOIS # <u>0042739</u>	Report Period Beginning: <u>01/01/04</u>	Ending: <u>12/31/04</u>
------------------------------------------------------------------------	----------------------------------------------	-------------------------------------------------	--------------------------------

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
 If YES, give association name and amount. N/A

(3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
 What was the average life used for new equipment added during this period? 6.5 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 70,081 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
 If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 122,976
 This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 11,764 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 0
 d. Have vehicle usage logs been maintained? Adequate records have been maintained.
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
 Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
 Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	302,180	29,761	15,587	347,528	0	347,528	0	347,528
2. Food Purchase	0	302,136	0	302,136	0	302,136	-11,764	290,372
3. Housekeeping	275,812	30,246	0	306,058	0	306,058	324	306,382
4. Laundry	69,211	22,305	0	91,516	0	91,516	-2,155	89,361
5. Heat and Other Utilities	0	0	192,604	192,604	0	192,604	3,703	196,307
6. Maintenance	32,586	0	94,288	126,874	0	126,874	47,573	174,447
7. Other (specify)*	0	0	0	0	0	0	5,354	5,354
8. Total General Services	679,789	384,448	302,479	1,366,716	0	1,366,716	43,035	1,409,751
9. Medical Director	0	0	30,825	30,825	0	30,825	0	30,825
10. Nursing & Medical Records	3,242,696	245,406	51,148	3,539,250	0	3,539,250	62,539	3,601,789
10a. Therapy	0	0	961,217	961,217	0	961,217	0	961,217
11. Activities	210,700	19,281	3,467	233,448	0	233,448	0	233,448
12. Social Services	91,235	0	2,909	94,144	0	94,144	0	94,144
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	7,562	7,562
16. Total Health Care & Programs	3,544,631	264,687	1,049,566	4,858,884	0	4,858,884	70,101	4,928,985
17. Administrative	108,768	0	1,027,802	1,136,570	0	1,136,570	-922,544	214,026
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	56,793	56,793	0	56,793	10,222	67,015
20. Fees, Subscriptions & Promotion	0	0	13,320	13,320	0	13,320	971	14,291
21. Clerical & General Office	245,765	34,548	19,396	299,709	0	299,709	296,603	596,312
22. Employee Benefits & Payroll	0	0	669,104	669,104	0	669,104	11,764	680,868
23. Inservice Training & Education	0	0	1,476	1,476	0	1,476	0	1,476
24. Travel and Seminar	0	0	2,582	2,582	0	2,582	4,039	6,621
25. Other Admin. Staff Trans	0	0	2,962	2,962	0	2,962	10,391	13,353
26. Insurance-Prop.Liab.Malpractice	0	0	206,295	206,295	0	206,295	4,626	210,921
27. Other (specify)*	0	0	0	0	0	0	45,620	45,620
28. Total General Adminis	354,533	34,548	1,999,730	2,388,811	0	2,388,811	-538,308	1,850,503
29. Total General Administrative	4,578,953	683,683	3,351,775	8,614,411	0	8,614,411	-425,172	8,189,239
30. Depreciation	0	0	71,199	71,199	0	71,199	178,377	249,576
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	4,242	4,242	0	4,242	303,103	307,345
33. Real Estate	0	0	0	0	0	0	521,059	521,059
34. Rent - Facility & Grounds	0	0	1,698,477	1,698,477	0	1,698,477	-1,696,985	1,492
35. Rent - Equipment & Vehicles	0	0	8,512	8,512	0	8,512	3,146	11,658
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,782,430	1,782,430	0	1,782,430	-691,300	1,091,130
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	314,035	0	314,035	0	314,035	0	314,035
40. Barber and Beauty Shop	0	0	20,675	20,675	0	20,675	0	20,675
41. Coffee and Gift Shops	0	0	7,274	7,274	0	7,274	0	7,274
42. Provider Participation	0	0	122,976	122,976	0	122,976	0	122,976
43. Other (specify):*	0	0	188,470	188,470	0	188,470	-188,470	0
44. Total Special Cost Ce	0	314,035	339,395	653,430	0	653,430	-188,470	464,960
45. Grand Total	4,578,953	997,718	5,473,600	11,050,271	0	11,050,271	-1,304,942	9,745,329

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	466,110	478,916
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	2,138,871	2,138,871
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	61,273	61,273
7. Other Prepaid Expenses	15,138	15,138
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	109,184
10. Total current assets	2,681,392	2,803,382
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	7,430	7,430
13. Land	0	522,683
14. Buildings, at Historical Cost	0	5,143,342
15. Leasehold Improvements, Historical Cost	627,173	874,358
16. Equipment, at Historical Cost	372,621	1,014,230
17. Accumulated Depreciation (book methods)	-333,304	-2,854,685
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	37,270	37,270
23. other (specify):	0	44,919
24. Total Long-Term Assets	711,190	4,789,547
25. Total Assets	3,392,582	7,592,929
CURRENT LIABILITIES		
26. Accounts Payable	448,764	448,764
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	400,000	400,000
30. Accrued Salaries Payable	285,119	285,119
31. Accrued Taxes Payable	2,371	2,371
32. Accrued Real Estate Taxes	0	531,000
33. Accrued Interest Payable	0	25,907
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	513,205	109,022
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,649,459	1,802,183
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	4,605,669
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	4,605,669
46. Total Liabilities	1,649,459	6,407,852
47. Total Equity	1,743,123	1,185,077
48. Total Liabilities and Equity	3,392,582	7,592,929

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,656,385
2. Discounts and Allowances for all Levels	-977,184
Subtotal - Inpatient Care	9,679,201
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,848,578
7. Oxygen	2,156
Subtotal - Ancillary Revenue	1,850,734
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	9,194
13. Barber and Beauty Care	25,387
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	11
16. Rental of Facility Space	0
17. Sale of Drugs	397,013
18. Sale of Supplies to Non-Patients	0
19. Laboratory	26,637
20. Radiology and X-Ray	20,078
21. Other Medical Services	58,885
22. Laundry	2,155
Subtotal - Other Operating Revenue	539,360
24. Contributions	0
25. Interest and Other Investments Income	17,309
Subtotal - Non-Operating Revenue	17,309
27. Other Revenue (specify):	0
28. Other Revenue (specify):	1,549
Subtotal - Other Revenue	1,549
30. Total Revenue	12,088,153
31. General Services	1,366,716
32. Health Care	4,858,884
33. General Administration	2,388,811
34. Ownership	1,782,430
35. Special Cost Centers	530,454
35. Provider Participation Fee	122,976
37. Other	0
40. Total Expenses	11,050,271
41. Income Before Income Taxes	1,037,882
42. Income Taxes	0
43. Net Income or Loss for the Year	1,037,882

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